JOHNS HOPKINS HEALTHCARE LLC
FACILITY APPLICATION FOR
NETWORK PARTICIPATION

INSTRUCTIONS

SUBMIT THE FOLLOWING DOCUMENTS WITH THE COMPLETED APPLICATION FOR EACH LOCATION

- Copy of facility state license.
- Accreditation certificate, if applicable (If the facility is not nationally accredited, a copy of the survey and approval letter from a regulatory body can be submitted.)
- Evidence of Medicare and/or Medicaid Certification.
- Copy of facility professional liability insurance certificate with JHHC required liability limits of coverage (facility name and specific location must be listed as the Insured.)
- Facility policy for reporting adverse actions.
- Documentation of adverse determination by regulatory body (copy of Corrective Action Plan, approval letter, and corrective action follow-up approval letter.)
- Tricare NQMC certificate, if applicable

MAIL APPLICATION AND DOCUMENTS TO:

JOHNS HOPKINS HEALTHCARE LLC
ATTENTION: PROVIDER RELATIONS
6704 CURTIS COURT
GLEN BURNIE, MD 21060

JOHNS HOPKINS HEALTHCARE LLC
FACILITY APPLICATION FOR NETWORK PARTICIPATION

I. FACILITY LOCATION

NAME OF FACILITY: _____

ADDRESS: _____ SERVICE AREA: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ FAX: _____

II. FACILITY CONTACT PERSON

NAME: _____ PHONE: _____

EMAIL: _____ FAX: _____

III. FACILITY SERVICES

SPECIAL SERVICES: _____ NO. OF BEDS: _____

IV. TYPE OF FACILITY

- ❑ Acute Care Hospital
- ❑ Home Health Agency
- ❑ Skilled Nursing Facility
- ❑ Freestanding Surgical Center
- ❑ Resident Treatment Center
- ❑ Outpatient Radiology Center
- ❑ Hospice
- ❑ Inpatient Substance Abuse Treatment Center
- ❑ Outpatient Substance Abuse Treatment Center
- ❑ Other: _____

V. BILLING INFORMATION

FACILITY FEDERAL TAX ID #: _____

MEDICARE #: _____

MEDICAID #: _____

TAXONOMY #: _____ NPI#: _____

VENDOR/BILLING NAME: _____

BILLING ADDRESS (if different): _____

CITY: _____ STATE: _____ ZIP: _____

CONTACT PERSON: _____

PHONE: _____ FAX: _____

VI. LICENSE INFORMATION
(Include all States for which your facility is licensed)

STATE LICENSE NO.: _____

STATE LICENSE NO.: _____

VII. ACCREDITATION INFORMATION

- ❑ AAAASF Accreditation
- ❑ AAAHC Accreditation
- ❑ ACHC Accreditation
- ❑ CARF Accreditation
- ❑ CHAP Accreditation
- ❑ JCAHO Accreditation
- ❑ Other: _____

VIII. PROFESSIONAL LIABILITY INSURANCE COVERAGE
(Attach a copy of the certificate of insurance)

NAME OF CARRIER: _____

POLICY NO: _____ EXPIRATION DATE: _____

LIMITS OF COVERAGE: $ _____ PER INCIDENT / $ _____ AGGREGATE

IX. ADDITIONAL QUESTIONS
Please explain affirmative answers.

A.	Has your facility ever been investigated by any licensing authority and/or other regulatory agency (e.g., OSHA, CLIA, etc.)?	❑ Yes	❑ No
B.	Has your facility received a statement of deficiencies requiring a plan of correction from the state?	❑ Yes	❑ No
C.	Has your facility ever been investigated by any private, federal, or state agency concerning your participation in any private, federal, or state health insurance program (e.g., HMO, Medicare, Medicaid)?	❑ Yes	❑ No
D.	Has your facility ever been subject to probation proceedings, suspended, sanctioned or otherwise restricted from participating in any private, federal, or state health insurance program (e.g., HMO, Medicare, Medicaid)?	❑ Yes	❑ No

E. Has your facility ever received a determination from any Professional Review Organization indicating a gross and flagrant quality concern? ❑ Yes ❑ No

F. Has your facility ever had any malpractice claims? ❑ Yes ❑ No

(Please check "Not Applicable" for questions that do not apply to non-ASC facilities. Provide copies of documentation for the following information as appropriate.)

GOVERNING BODY AND MANAGEMENT

Does facility have a governing body that assumes full legal responsibility for determining, implementing, and monitoring policies governing the facility's total operation and for ensuring that these policies are administered so as to provide quality health care in a safe environment? ❑ Yes ❑ No

MEDICAL STAFF

Is the medical staff accountable to the governing body? ❑ Yes ❑ No

MEMBERSHIP AND CLINICAL PRIVILEGES

Are the members of the medical staff legally and professionally qualified for the positions to which they are appointed and for the performance of privileges granted? ❑ Yes ❑ No

REAPPRAISALS

Medical Staff privileges must be periodically reappraised by the facility. The scope of the procedures performed in the facility must be periodically reviewed and amended as appropriate. Indicate how often privileges are reappraised:

❑ _____ months ❑ _____ years

OTHER PRACTITIONERS

Does the facility have established policies and procedures that are approved by the governing body for overseeing and evaluating the clinical privileges of practitioners other than physicians who are assigned patient care responsibilities? ❑ Yes ❑ No

NURSING SERVICES ❑ **Not Applicable**

Are the nursing services directed and staffed to assure that the nursing needs of all patients are met? ❑ Yes ❑ No

ORGANIZATION AND STAFFING

Does the organization follow recognized standards of practice and follow emergency treatment protocols as it relates to patient care, and which are delineated for all nursing and/or service personnel? ❑ Yes ❑ No

ADVERSE OUTCOMES

Does facility have a policy that identifies how it reports adverse outcomes? If "No" explanation required. ❑ Yes ❑ No

_____
_____
_____

HOSPITILIZATION

Does facility have an effective procedure for immediate transfer to a hospital for patients requiring emergency medical care beyond the capabilities of the facility? If "No" explanation required. ❑ Yes ❑ No

_____
_____
_____

SURGICAL SERVICES ❑ **Not Applicable**

Does facility have qualified physicians to perform surgical procedures who have been granted clinical privileges by the governing body of the facility in accordance with approved policies and procedures of the facility? If "No" explanation required. ❑ Yes ❑ No

_____
_____
_____

ANESTHETIC RISK AND EVALUATION ❑ **Not Applicable**

Does a physician examine the patient immediately before surgery to evaluate the risk of anesthesia and of the procedure to be performed? ❑ Yes ❑ No

Does a physician perform evaluation for proper anesthesia recovery before patient is discharged? ❑ Yes ❑ No

ADMINISTRATION OF ANESTHESIA ❑ **Not Applicable**

Anesthetics must be administered by only a qualified anesthesiologist or physician qualified to administer anesthesia, a certified registered nurse anesthetist, or a supervised trainee in an approved educational program. ❑ Yes ❑ No

All anesthesia is administered by:

_____

DISCHARGE ❑ **Not Applicable**

Are all patients discharged in the company of a responsible adult? If "No" explanation is required. ❑ Yes ❑ No

_____

_____

_____

ATTACHMENT A

Please complete all applicable sections in the following data grid.

Administrative Departments	***Contact***	***Title***	***Telephone/Fax Number***
Accounts Payable/Billing			
Admitting Office			
Information Systems			
Social Work/Discharge Planning			
Utilization Management/ Quality Assurance			
Credentialing/Medical Staff Office			
Ancillary Services ❑ **Not Applicable**	***Part of Contract (Yes/No)***	***Contact/Title***	***Telephone/Fax Number***
Anesthesiology			
Radiology			
Laboratory			
Emergency Room			

JOHNS HOPKINS
MEDICINE
JOHNS HOPKINS
HEALTHCARE

ATTESTATION STATEMENT AND AUTHORIZATION TO RELEASE INFORMATION

I authorize **Johns Hopkins HealthCare LLC** and its affiliates, subsidiaries or related entities to consult with malpractice carriers, licensing boards, professional organizations**,** and other persons to obtain and verify information and I release the Carrier and its employees and agents from any and all liability for their acts performed in good faith and without malice in obtaining and verifying such information and in evaluating our application; and,

I consent to the release by any person to the Carrier of all information that may be reasonably relevant to an evaluation of the facility, including any information relating to any disciplinary action, suspension or limitation of privileges, and hereby release any such person providing such information from any and all liability for doing so.

I warrant that all of the information that I have provided and the responses that I have given are correct and complete to the best of my knowledge and belief. I understand that willful falsification or willful omission of this information will be grounds for rejection or termination.

I further agree to notify JHHC of any change to the information provided in this application within thirty (30) days of any such change. I understand that any information provided in this application that is not publicly available will be treated as confidential by JHHC.

SIGNATURE	**DATE**
PRINTED NAME	**TITLE**